

§ 409.1

Subpart G—Hospital Insurance Deductibles and Coinsurance

- 409.80 Inpatient deductible and coinsurance: General provisions
- 409.82 Inpatient hospital deductible.
- 409.83 Inpatient hospital coinsurance.
- 409.85 Skilled nursing facility (SNF) care coinsurance.
- 409.87 Blood deductible.
- 409.89 Exemption of kidney donors from deductible and coinsurance requirements.

Subpart H—Payments of Hospital Insurance Benefits

- 409.100 To whom payment is made.
- 409.102 Amounts of payment.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 48 FR 12541, Mar. 25, 1983, unless otherwise noted.

EDITORIAL NOTE: Nomenclature changes to part 409 appear at 62 FR 46037, Aug. 29, 1997.

Subpart A—Hospital Insurance Benefits: General Provisions

§ 409.1 Statutory basis.

This part is based on the identified provisions of the following sections of the Social Security Act:

(a) Sections 1812 and 1813 establish the scope of benefits of the hospital insurance program under Medicare Part A and set forth deductible and coinsurance requirements.

(b) Sections 1814 and 1815 establish conditions for, and limitations on, payment for services furnished by providers.

(c) Section 1820 establishes the critical access hospital program.

(d) Section 1861 describes the services covered under Medicare Part A, and benefit periods.

(e) Section 1862(a) specifies exclusions from coverage; and section 1862(h) requires a registry of pacemakers.

(f) Section 1881 sets forth the rules for individuals who have end-stage renal disease (ESRD), for organ donors, and for dialysis, transplantation, and other services furnished to ESRD patients.

[60 FR 50441, Sept. 29, 1995]

§ 409.2 Scope.

Subparts A through G of this part describe the benefits available under

42 CFR Ch. IV (10–1–00 Edition)

Medicare Part A and set forth the limitations on those benefits, including certain amounts of payment for which beneficiaries are responsible.

[48 FR 12541, Mar. 25, 1983, as amended at 50 FR 33033, Aug. 16, 1985]

§ 409.3 Definitions.

As used in this part, unless the context indicates otherwise—

Arrangements means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services.

Covered refers to services for which the law and the regulations authorize Medicare payment.

Nominal charge provider means a provider that furnishes services free of charge or at a nominal charge and is either a public provider, or another provider that (1) demonstrates to HCFA's satisfaction that a significant portion of its patients are low-income, and (2) requests that payment for its services be determined accordingly.

Participating refers to a hospital or other facility that meets the conditions of participation and has in effect a Medicare provider agreement.

Qualified hospital means a facility that—

(a) Is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled;

(b) Is not primarily engaged in providing skilled nursing care and related services for inpatients who require medical or nursing care;

(c) Provides 24-hour nursing service in accordance with Sec. 1861(e)(5) of the Act;

(d) If it is a U.S. hospital, is licensed, or approved as meeting the standards for licensing, by the State or local licensing agency; and

(e) If it is a foreign hospital, is licensed, or approved as meeting the standard for licensing, by the appropriate Canadian or Mexican licensing agency, and for purposes of furnishing non-emergency services to U.S. residents, is accredited by the Joint Commission on Accreditation of Hospitals